PRINTED: 10/13/2011

	Γ OF HEALTH AND HUM R MEDICARE & MEDIC						RM APPROVED B NO. 0938-0391
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ĺ	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 09/28/2011	
	PROVIDER OR SUPPLIEF		3	025 W.	DDRESS, CITY, STATE, ZIP CODE SYCAMORE STREET O, IN46901		
(X4) ID PREFIX TAG R0000	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	Licensure Survey Survey dates: September 27 and Facility number: Provider number: AIM number: N Survey team: Donna M. Smith Tammy Alley, R	dd 28, 2011  011075 :: 011075 i/A  , RN, TC  N W (September 27, 2011) N (training) :	R000	0	The following is the Plan of Correction for Sterling House Kokomo in regards to the Statement of Deficiencies for annual survey completed on 9/28/2011. This Plan of Correction is not to be constructed as an admission of or agreer with the findings and conclus in the Statement of Deficience or any related sanction or fin Rather, it is submitted as confirmation of our ongoing efforts to comply with statuto and regulatory requirements this document, we have outli specific actions in response identified issues. We have reprovided a detailed response each allegation or finding, no have we identified mitigating factors. We remain committe the delivery of quality health services and will continue to make changes and improver to satisfy that objective.	r the rued ment sions cies, e. rry . In ned to not e to or ed to care	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Quality review completed on October 4,

These state findings are cited in accordance with 410 IAC 16.2.

2011 by Bev Faulkner, RN

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W7IX11

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		00	(X3) DATE SURVEY COMPLETED 09/28/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  3025 W. SYCAMORE STREET  KOKOMO, IN46901				
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R0042	annual survey of the state surveyors, and effect with respect subsequent survey. Based on observed facility failed to a completed survey survey book for the and/or visitors respected during the potential to affect families and/or visitors and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected during the potential to affect families and/or visitors respected	results of the most recent the facility conducted by the my plan of correction in to the facility, and any ys.  ations and interview, the ensure the most recent y was included in the the residents, families view for 1 of 2 days the survey. This had the to 33 of 33 residents, isitors in the facility.  9:15 a.m., the survey end on the table in front of the most recent survey revery book was a reconducted on 8/17/10.  Formation related to the mpleted on 10/05/10.  8:25 a.m., during an ministrator indicated she y the last survey was not	RO	0042	R 042: Resident Rights (non-compliance) What corrective action(s) will be accomplished for those residents found to have be affected by the alleged deficient practice? The community has consistent had a practice of keeping copies of their survey lette and findings in a binder on table outside the Executive Director's office, with a sig directly overhead, stating if location. On the date in question, the surveyor fou the most recent survey lette be missing from this binde This survey letter was one page only-stating the community was deficiency on their last annual survey has not been determined in would have removed the le as all other surveys were se the binder. Once the Executive Director was notified, she immediately obtained a copy of the deficiency-free letter and placed it in the binder, and notified the surveyors of it presence. How will the fac- identify other residents with	een  ily  ors  or a  el  in  its  or-free  or. · It  who  etter,  ettill in	10/15/2011

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/28/2011			
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				the potential to be affect the same alleged deficit practice and what correaction will be taken? Residents and interested parties had the potential affected by the alleged non-compliant practice. Anyone who was havin difficulty locating the sresults will now be direan enlarged sign to che binder directly below the and/or if moved by a recorvisitor, advising the interested party to ask executive Director or a associate for their own What measures will be place or what systemic changes will the facility to ensure the alleged depractice does not recur anyone who was havin difficulty locating the sresults will now be directed the binder, and/of the Executive Director own copy, in the event something has been recontents are to be audited by the Executive Director/Designee. The now a note in the surved directing readers who was even the Wellness Center copy for them, instead removing any of the contended to the surved directing readers who was a contended to the cont	ent ective ed al to be  i g urvey ected by eck the ne sign, sident  the ny copy. put in  make eficient efici			

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE COI  A. BUILDING  B. WING	NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/28/2011
NAME OF P	ROVIDER OR SUPPLIER		STREET A	DDRESS, CITY, STATE, ZIP CODE	
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TAG	*	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	· Associates will receive education on the new dire and will be available to ma copies for any visitors wis to receive one from a dupl file which will be kept in the wellness center. How will corrective actions be monitored to ensure the deficient practice will not it.e., what quality assurance programs will be put in play. The Executive Director/Designee will review results of audits weekly and make recommendations/change based on the findings and recommendations of the Committee. By what date we these systemic changes be implemented? · 10-15-11 accorrective action(s) will be accomplished for those residents found to have be affected by the alleged deficient practice? The community has consistently practice of keeping copies of survey letters and findings in binder on a table outside the Executive Director's office, sign directly overhead, statil location. On the date in question, the surveyor found most recent survey letter to missing from this binder. Survey letter was one page only-stating the community deficiency-free on their last annual survey. It has not	ctive like lining licate lie lithe  recur, le lice?  lew lid s, lid A lill le lith le

	AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 09/28/2011			
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				determined who would have removed the letter, as all oth surveys were still in the bind. Once the Executive Director notified, she immediately obtained a copy of the deficiency-free letter and plain the binder, and notified the surveyors of its presence. Will the facility identify otheresidents with the potential be affected by the same all deficient practice and what corrective action will be taken to easily the survey results will now be directed by the alleged non-compliant practice. Are who was having difficulty look the survey results will now be directed by an enlarged signing check the binder directly beleated the sign, and/or if moved by resident or visitor, advising the interested party to ask the Executive Director or any associate for their own copy. What measures will be put place or what systemic changes will the facility mate to ensure the alleged deficit practice does not recur? Anyone who was having difficulting the survey results who we directed to check the binder, and/or ask the Executive Director for their own copy, in event something has been removed. An audit tool will placed in the survey binder and the contents are to be audited daily by the Executive	er er. · was  ced it e How er I to eged t ken?  e nyone ating e to ow a he  in ke ient culty iill e utive n the ll be and			

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	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL B. WINC	DING	00 	COMPL 09/28/2	ETED	
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					Director/Designee. There is a note in the survey binder directing readers who want to make copies to have someous the Wellness Center make a for them, instead of removing of the contents. Associates receive education on the new directive and will be available make copies for any visitors wishing to receive one from a duplicate file which will be ket the wellness center. How we the corrective actions be monitored to ensure the deficient practice will not rei.e., what quality assurance programs will be put in place. The Executive Director/Designee will review results of audits weekly and recommendations/changes, based on the findings and recommendations of the QA committee. By what date will these systemic changes be implemented? 10-15-11	o ne in copy g any will w e to a ept in ill ecur, ce? w make		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W7IX11

Facility ID:

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If continuation sheet

Page 6 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C  A. BUILDING  B. WING	ONSTRUCTION  00	(X3) DATE COMP 	LETED	
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R0090	(g) The administration overall management responsibilities of include, but are not (1) Informing the coccurrence that disafety, or health ounusual occurrence telephone, followed written report only electronic mail to the twenty-four (24) hooccurrences include (A) epidemic outbin (B) poisonings; (C) fires; or (D) major accident If the division cannot be made to the enpublished by the coccurrence or other telephone, followed written report only electronic mail to the twenty-four (24) hooccurrences include (A) epidemic outbin (B) poisonings; (C) fires; or (D) major accident If the division cannot be made to the enpublished by the coccurrence or other telephone, followed written in the division of medical nursing care or other telephone, followed with the enpublished by the coccurrence in the division of medical nursing care or other telephone, followed by the coccurrence in the division of medical nursing care or other telephone, followed by the coccurrence in the division of medical nursing care or other telephone, followed by the coccurrence in the division cannot be made to the enpublished by the coccurrence in the division cannot be made to the enpublished by the coccurrence in the division cannot be made to the enpublished by the coccurrence in the division cannot be made to the enpublished by the coccurrence in the division cannot be made to the enpublished by the coccurrence in the division cannot be made to the enpublished by the coccurrence in the control of the division cannot be made to the enpublished by the coccurrence in the coccurren	tor is responsible for the ent of the facility. The the administrator shall of limited to, the following: livision within twenty-four ming aware of an unusual rectly threatens the welfare, of a resident. Notice of the may be made by do by a written report, or by a that is faxed or sent by the division within the four time period. Unusual de, but are not limited to: reaks;  Is.  In the reached, a call shall the regency telephone number in itsion. Its ging for or assisting with the al, dental, podiatry, or the health care services as the esident or resident's legal extor approval prior to the dividual under eighteen (18) adult facility. It is a call time tes the:  In name; and resources worked during the past	IAU			DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A BUILDING  00			(X3) DATE SURVEY  COMPLETED		
THEFTERN	or condition	BENTH ION HONDER.	A. BUILDING			09/28/2011	
			B. WIN		ADDRESS CITY STATE ZIR CODE	00.20.2	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  /. SYCAMORE STREET		
STERLIN	IG HOUSE OF KOK	КОМО			MO, IN46901		
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PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	notice posted of th	•					
		ports of surveys conducted each facility for a period of					
		making the reports available					
		ny member of the public					
	upon request	·					
	Based on observa	ations and interview, the	R(	0090	R 090 Administration and		10/15/2011
	facility failed to	ensure the posting of the			Management-deficiency W		
	survey sign was	visible for the location of			corrective action(s) will be accomplished for those	!	
	the survey book	for residents, families,			residents found to have be	en	
	and/or visitors re	eview for 1 of 2 days			affected by the alleged		
	notential to affect 33 of 33 residents community has consi		deficient practice? The				
					community has consistently		
	1 ^	risitors in the facility.	practice of keeping copies of				
				survey letters and findings in a binder on a table outside the			
	Findings include				Executive Director's office,		
		•			large sign directly overhead		
	   1 On 9/27/11 at	9:15 a.m., no posting of			stating its location. On the		
		e survey book was			in question, the surveyor inf the Executive Director that s		
		s same time, the survey			was unable to find the sign		
		ed on the table in front of			did not immediately locate t		
		The most recent survey			survey binder on the table b		
		rvey book was the			the sign. The sign was poir		
	_	conducted on 8/17/10.			out to the surveyor, who the proceeded to inform the	311	
		Formation related to the			Executive Director that she	felt	
					the sign was not easy enough	gh to	
	annuai survey co	impleted on 10/05/10.			find. · In response, the		
	2 On 0/27/11 -4	0.25 a ma dannia			Executive Director, then immediately replaced a port	ion of	
		8:25 a.m., during an			the sign and used 72 point f		
		ministrator indicated she			direct interested parties		
		rvey sign behind several			immediately below the sign		
ı		e. She indicated the			the survey binder. This sur	-	
ı		ther items on the table in			binder was found to be miss one page only-stating the	sing	
l		e would get moved			community was deficiency-f	ree on	
		y by the residents. She			their last annual survey. · I		
	also indicated the	e sign should be located			not been determined who w		

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		09/28/2011
NAME OF E	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF TROVIDER OR SOFTEIER			3025 V	W. SYCAMORE STREET	
STERLIN	STERLING HOUSE OF KOKOMO			MO, IN46901	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDENCE BLANCE CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	on the window si	ill/shelf above where the	İ	have removed the letter, as a	all
	survey book was	located.		other surveys were still in the	•
				binder. It is also impossible t	•
				determine why the survey sign	
				was not visible to the survey	or.·
			1	A new sign is now in place directing interested parties to	,
				view a copy of the survey bir	
				which is available on the tab	I
				outside the Executive Director	I
				office, and now includes the	
				directive that additional copie	es
				may be made by any associa	ate in
				the wellness center, instead	I
				removing the contents. How	will
				the facility identify other	.,
				residents with the potential	
				be affected by the same all deficient practice and what	
				corrective action will be tal	•
				Residents and interested	len:
				parties had the potential to b	e l
				acted by the alleged	
				non-compliant practice. An	yone
				who was having difficulty loc	· I
				the survey results will now be	
				directed by a new sign to che	•
				the binder directly below the	- 1
				and/or if moved by a residen	I
				visitor, advising the intereste party to ask the Executive	u
				Director or any associate for	their
				own copy. What measure	I
				will be put in place or what	
				systemic changes will the	
				facility make to ensure the	
				alleged deficient practice d	oes
				not recur? · Anyone who w	•
				having difficulty locating the	
				survey results will now be	
				directed to check the binder,	I
				and/or ask the Executive Dir	ector

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
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IAU	REGULATORI OR	LICE IDENTIFY LING INFORMATION)	IAU	for their own copy, in the evisomething has been removed. An audit of the survey binder the contents will be completed daily by the Executive. Director/Designee. There is a note in the survey binder directing readers who want to make copies to have any associate in the Wellness Comake a copy for them, insteremoving any of the content Associates will receive educe on the new directive and will available to make copies for visitors wishing to receive or from a duplicate file which we kept in the wellness center. will the corrective actions monitored to ensure the deficient practice will not rive, what quality assurance programs will be put in plate. The Executive Director/Designee will review results of audits weekly and recommendations/changes, based on the findings and recommendations of the QA committee. By what date with these systemic changes be implemented? 10-15-11	ent ed. · r and ed s now to enter ad of s.· ation I be any ne vill be How be ecur, e ce? w make

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C  A. BUILDING	00	(X3) DATE SURVEY  COMPLETED  00/28/2011			
			B. WING 09/28/2011				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  3025 W. SYCAMORE STREET  KOKOMO, IN46901				
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R0092	disaster preparedres continuity of care of emergency as follows:  (1) Fire exit drills in transmission of a final simulation of emerexcept that the more residents to safe a building is not requested to conducted quarter familiarize all faciliand emergency acconditions. At least held every year. We between 9 p.m. an announcement may audible alarms.  (2) At least every shall attempt to he in conjunction with record of all training documented with the personnel present Based on record the facility failed conducted quarter fire drills reviewed.  Findings include  1. On 9/27/11 at were provided by fire drills were continued to the same as follows:  10/13/10 at 3:30	in facilities shall include the fire alarm signal and regency fire conditions, overment of nonambulatory ireas or to the exterior of the uired. Drills shall be ly on each shift to ty personnel with signals of the united under varied to the drills are conducted at twelve (12) drills shall be larger than the local fire department. A log and drills shall be the names and signatures of sent.  The view and interviews, to ensure fire drills were arely on each shift for the led from 10/10 to 8/11.	R0092	R 092 Administration and Management-non-complia What corrective action(s) be accomplished for those residents found to have be affected by the alleged deficient practice? No resident was affected by the alleged non-compliant practice Maintenance Director previously in charge of drills longer employed at this community. The new Maintenance Director has be educated on the expectation this community conducts fir quarterly on each shift. Whe drills are conducted between	will e een eice. · s is no een n that e drills en		

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Event ID:

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Facility ID:

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If continuation sheet

Page 11 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 09/28/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3025 W. SYCAMORE STREET STERLING HOUSE OF KOKOMO KOKOMO, IN46901 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 10:00 a.m.; 2/14/11 at 8:45 a.m.; 3/16/11 pm and 6am, a coded announcement is used instead of at 3:20 p.m.; 4/07/11 at 4:45 p.m.; 5/14/11 an audible one. In addition, the at 11 a.m.; 6/09/11 at 8:15 (unspecified); community maintenance director 7/20/11 at 10:30 (unspecified); and will request and document fire department assistance with a drill 8/24/11 at 9:25 (unspecified). at least every 6 months. How will the facility identify other 2. On 9/27/11 at 12:10 p.m., the Director residents with the potential to of Nursing indicated the shifts were 6 a.m. be affected by the same alleged to 2 p.m.; 2 p.m. to 10 p.m.; and 10 p.m. deficient practice and what corrective action will be taken? to 6 a.m. Residents and associates have the potential to be affected by the On 9/27/11 at 2:10 p.m., during an alleged deficient practice. The interview the Administrator indicated the new Maintenance Director has been educated on the expectation unspecified times for the above fire drills that this community conducts fire were conducted in the a.m.'s as drills quarterly on each shift. determined by the staff attendance. She When drills are conducted also indicated the fire drills had not been between 9 pm and 6am, a coded announcement is used instead of completed quarterly on all shifts. an audible one. In addition, the community maintenance director will request and document fire department assistance with a drill at least every 6 months. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? · Copies of documentation for each fire drill completed at the community will be kept in a location to be designated by the Executive Director. The Executive Director will review documentation of all fire drills requested and completed monthly to monitor compliance with

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE S	ATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED	
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			B. WING			03/20/20	011	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE			
1 11 11 11 01 1	no vident on borreit.		3025 W. SYCAMORE STREET					
	IG HOUSE OF KOK	COMO	KOKOMO, IN46901					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE	
					expectations. How will the corrective actions be monitored to ensure the deficient practice will not rei.e., what quality assurance	•		
R0144		all be clean, orderly, and in a			programs will be put in place. The Maintenance Director report results of monthly fire to the Safety Committee, alo with producing written documentation of his attemp schedule fire drills with the fired department at least every 6 months. The Executive Dir will make recommendations regarding further actions, bas on monthly findings and documentation review. By we date will these systemic changes be implemented? 10-15-11_	will drills ang ts to re rector sed		
	shall provide rease residents. Based on observe and interviews, the ensure a clean, so environment relative wallpaper, doors window sills, fluceiling vents observey for 1 of 1	ted to the carpeting, dining room curtains, orescent lights, and erved during the annual observation day. This to affect 33 of 33 g in the facility.	R01	44	R 144- Sanitation and Safet Standards deficiency What corrective action(s) will be accomplished for those residents found to have be affected by the alleged deficient practice? Apart 605: Carpet cleaned and bu areas were fixed by a local carpeting services vendor. hallway: wallpaper was repaired. Apartment 511: Carpet cleaned and repaired Wallpaper in the gallery was secured. Exit door area was cleaned of debris. Hallway	en ment libbled 500	10/15/2011	

l l		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		09/28/2011
NAME OF I	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	KOVIDER OR SUPPLIER		3025 W	/. SYCAMORE STREET	
	IG HOUSE OF KOK			лО, IN46901	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	outside 205 was repainted a	DATE
	1. On 9/27/11 at	· · · · · · · · · · · · · · · · · · ·		caulked. The carpet in the	• • • • • • • • • • • • • • • • • • •
	following was ob	oserved:		way and inside Apartment 10	- I
				was cleaned. The carpet in	
		was open with the		gallery was cleaned. Scuffs	• • • • • • • • • • • • • • • • • • •
		d in the recliner. On the		bottoms of apartment doors	
	carpet, there were	e scattered dark brown to		door trim were repainted. T fluorescent light in the front	ne
	black floor areas	of varying sizes ranging		hallway of the electrical roon	n has
	from quarter size	to saucer size. These		been assessed for safety.	
	areas were observ	ved in the middle of the		front lobby sitting room wind	
	room from the do	porway to the recliner at		and ledges have been clean	• • • • • • • • • • • • • • • • • • •
		he room. Also, six		The Florida room window sill have been cleaned. In the	ls
		nging from a small ball to		mechanical room near the ni	urses
		1/2 of a ball were also		station, a cover has been pla	
		nout this same area.		over the fluorescent lights.	
	ooser vea unrough	out this surre with		whirlpool room, the vent has	• • • • • • • • • • • • • • • • • • •
	There was brown	accumulated debris		cleaned and the stained area	I
		he door's metal threshold		been repainted. In the beau shop, the crack near the	aty
	_	s at the exit door at the		baseboard has been patched	d and
				the beauty shop thoroughly	
	end of this hallwa	ay,		cleaned. The ceiling vent in	
	A 1.11	7001 11 10:1		short hallway near the beaut	у
		ne 500 hallway, a 10 inch		shop was cleaned and repainted. The ceiling vent	near
	length area of loc			apartment 106 was cleaned	• • • • • • • • • • • • • • • • • • •
		oserved above the		repainted. The mechanical	• • • • • • • • • • • • • • • • • • •
	baseboard at the	corner of the hallway.		on the 100/200 hall now has	
				fixture in place. The storage	
		was observed opened.		room with housekeeping sup	•
	As one entered the room, a 4 inch			fixture. In the gallery, the co	I
	elongated spilled	red area was observed		vent above the counter was	3
	on the floor carpe	eting in the middle of the		repaired. How will the faci	- I
	room. The carpe	t was observed buckling		identify other residents wit	I
	up around the bas	seboard to the bathroom		the potential to be affected	by
	entryway.			the same alleged deficient practice and what corrective	/e
				action will be taken?	
	In the large area	in front of the		Residents have the potential	to
				L	<del> </del>

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	A RUILDING 00		COMPLETED	
			A. BUILDING B. WING 09/28/2011			011	
			B. WIN		DDDEGG GITW GTATE ZID GODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					. SYCAMORE STREET		
STERLIN	NG HOUSE OF KO	KOMO		KOKON	1O, IN46901		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re l	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	gallery/Grandma	a's kitchen room, several			be affected by the alleged		
	1 -	bserved attending an			deficient practice, and are		
		same area, 18 inches of			encouraged to report when the		
	1 *				notice areas in need of repai	r	
		the seam near the ceiling			within their privately held		
		ming apart. The exit			apartments, and the mainten director /designee is respons		
		of the short hallway			for documenting follow-up ac		
	behind this large	area was observed with			in a timely manner. A gener		
	an accumulation	of brown debris at each			cleaning schedule is in place		
	end of the metal	threshold.			common area cleaning. The		
					Executive Director/Designee	will	
	The hellwore eail	ling vent outside Room			be responsible for completion	n of	
					rounds to audit for		
		ed with a brown bordered			compliance. What measures	will	
	stained area mea	suring an irregular 2			be put in place or what		
	inches wide. In	this same stained area, a			systemic changes will the		
	small quarter siz	ed cracked opening was			facility make to ensure the		
	observed.	, ,			alleged deficient practice d		
					not recur? · Associates will		
	The compet in the	anteriorism and in the			re-educated by the Executive Director/Designee, regarding		
	1 ^	e entry way and in the			common area cleaning	'	
		101 was observed with			expectations. The Mainter	nance	
	dark brown stair	ned areas of varying			Director will be re-educated I		
	shapes and sizes	measuring up to the size			the Executive Director/Desig	-	
	of a quarter.				on record-keeping for all repa	airs,	
					both scheduled and		
	The hallway car	peting throughout the			un-scheduled. How will the		
		erved with various brown			corrective actions be		
					monitored to ensure the		
	to dark gray stained areas of various sizes from saucer size and larger. In the gallery/Grandma's kitchen area, a large area of dark brown/black stained carpeting was observed around the large				deficient practice will not re		
					i.e., what quality assurance		
					<ul><li>programs will be put in place</li><li>Observations and "Ready to</li></ul>		
					Company" Checklist will be	UI	
					utilized by one manager daily	, for	
	table and chairs.	_			the next 30 days to monitor	,	
					compliance with acceptable		
	Entry doors to 41.	o individual anartments			standards. The results of the	ese	
	I -	ne individual apartments			audits will be kept in a location	on	
	were observed so	curred below the	1				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE  A. BUILDING  B. WING	00		e survey pleted /2011	
	PROVIDER OR SUPPLIER		STREI 3025	ET ADDRESS, CITY, STATE, ZIP C S W. SYCAMORE STREET COMO, IN46901		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	doorknobs. The sizes from 1 inch the door with pair Room 203's door numbers 302, 30 204, 209, 108, 10 509, 511, and 40 doors by Room 2 Room 604, and Furim were also obvarious areas beleful. On 9/27/11 frop.m., the environ conducted with the Maintenance Supwas observed:  In the front hallway compared to the various seems with no covering individual bulbs;  As the various seems with the various seems with no covering individual bulbs;  As the various seems with no covering individual bulbs;  As the various seems with no covering individual bulbs;  As the various seems with no covering individual bulbs;  As the various seems with no covering individual bulbs;  As the various seems with no covering individual bulbs;	scuffed marks varied in a to across the width of an tobserved missing from the transfer to the served missing from the transfer to the served missing from the transfer to the served to the two attices to		determined by the E. Director, and will be weekly. Additional recommendations ar will be determined by Executive Director. Be will these systemic implemented? • 10	nd follow-up y the sy what date changes be	
	an interview indicated she had hired a company to clean the facility's hallway					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
			A. BUII B. WIN		<del></del>	09/28/2	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					SYCAMORE STREET		
	NG HOUSE OF KOK				//O, IN46901		015)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	DATE
		ndicated the stains came					
	1	inue to show up with					
		clean the carpeting.					
	•	e to Room 605, she peting had been replaced					
	1	also indicated she had					
	1 -	ny, who had laid the					
	1	e had not received a					
	response.						
		y sitting room, a layer of					
	1	k dust was observed on 3					
	of the 3 window	SIIIS.					
	In the main dinin	ig room, 5 of the 5					
		e observed with a layer					
		lack dust with a spider					
	web observed in	1 of the 5 windows. The					
	_	nins were observed with a					
	1	cumulated dust on the					
		irtains. Two of the					
	1 -	ere observed with an stained line marking					
	1 –	2 inches from the bottom					
	of the curtain par						
	January Pul						
	In the "Florida" r	room, the 3 window sills					
	were observed w	ith a layer of light gray,					
	loose dust.						
	In a gas11	agnical reasons are 4 th -					
		nanical room around the ocover was observed					
	· · · · · · · · · · · · · · · · · · ·	3 fluorescent lights.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI	IPLE CO	NSTRUCTION	(X3) DATE S COMPL		
ANDILAN	or connection	IDENTIFICATION NUMBER.	A. BUILDIN	NG	00	09/28/2	
			B. WING	TREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	₹	I		SYCAMORE STREET		
STERLIN	IG HOUSE OF KO	KOMO			O, IN46901		
(X4) ID		STATEMENT OF DEFICIENCIES	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		EFIX AG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		room, the ceiling vent	17	AG	BEIGHACT		DATE
	1 *	th a stained brown/white					
		e vent with the 2nd corner					
		ith gray dust hanging					
	from it.	itii giuy dust nunging					
	nom it.						
	In the beauty sho	op, upon entering the					
	1	elongated opening in the					
	· ·	ed above the baseboard					
	on the left side of	of the entry doorway.					
	Also, a layer of	light gray to browning					
	dust/debris was	observed along the walls					
	of the room. At	this same time during an					
	interview, the A	dministrator indicated the					
	beautician usual	ly cleaned the beauty					
	shop.						
	The ceiling vent	in the short hallway by					
		was observed with brown,					
		tained border around the					
	outside of this ve						
		y Room 106, one side of					
	ı	was observed with a small					
		brown area with a jagged					
		the vent. At this same					
	time during an ii						
		dicated the ceiling vent's					
		ound them had seemed to					
		elting snow this past					
	to it this summer	, the air conditioner added					
	io it uiis summei	1.					
	The mechanical	room located in the					

PRINTED: 10/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO  A. BUILDING	NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/28/2011	
	PROVIDER OR SUPPLIER		3025 W	ADDRESS, CITY, STATE, ZIP CODE  SYCAMORE STREET  MO, IN46901	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	cover over the flucture Also, the storage supplies was obsthe fluorescent li	s observed with no light morescent light fixture.  room with housekeeping erved with no cover on ght.  andma's kitchen room,			
	the ceiling vent a observed crumbl	bove the counter was y/cracked on 1 side of the a brown stained area			
	SCHEDULE" po Director of Nursi	SHIFT CLEANING plicy was provided by the ing on 9/28/11 at 9:10 t policy indicated the			
	"WEDNESDA 1. Dust window SUNDAYS 1. Sweep/mop b	sills common areas.			
R0270	with consideration (2) reasonable reli preferences; and	quirements and requests, of food allergies; gious, ethnic, and personal need for meals delivered to			
	interview, the fac	review, observation, and cility failed to ensure that rders for thickened	R0270	R 270 Food and Nutritional Services-deficiency What corrective action(s) will be accomplished for those	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL		onstruction 00	(X3) DATE COMPI	LETED	
			B. WING	G		09/28/2	011
	PROVIDER OR SUPPLIEF		•	3025 W	ADDRESS, CITY, STATE, ZIP CODE  1. SYCAMORE STREET  1. MO, IN46901	•	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
	liquids and sunn	lements were provided as			residents found to have be	een	
	1 ^ ^^	e physician for 1 of 2			affected by the alleged		
	1 1	1 2			deficient practice? · Resi	dent#	
		ed for thickened liquids			25: no adverse effects were	е	
	and supplements	s in sample of 7.			noted to this resident as a r		
	(Resident # 25)				of the alleged deficient prac		
					· Ensure supplements orde	ers are	
	Findings include	»:			now noted on Medication		
					Administration record to be provided by the nursing star	ff	
	The record for R	lesident # 25 was			following meals. • The rec		
	reviewed on 9/20				be initialed by the nursing s		
	Teviewed on 9/20	0/11 at 11 a.iii.			document compliance. · N		
					staff was advised to only su	pply	
	_	es included, but were not			cool or warm fluids for thick		
	limited to, deme	ntia and unavoidable			as opposed to iced fluids, a	s the	
	weight loss.				thickener will mix more		
					thoroughly. How will the fa	-	
	A recapitulation	of physician orders for			identify other residents wi the potential to be affected		
	_	or September 2011,			the same alleged deficient	-	
		er for nectar thickened			practice and what correct		
		re supplement three times			action will be taken? · Oth		
	1 -				residents with orders for		
	a day at 8 a.m., 1	12 noon, and 5 p.m.			supplements or thickened li		
					have the potential to be affe		
	_	observation on 9/27/11			by the alleged deficient practice this reason, the Haalth		
	1	.m. and 12:40 p.m.,			For this reason, the Health Wellness Director / Designe		
	Resident # 25 wa	as sitting in her			audited the clinical records		
	wheelchair at the	e dinning room table with			residents with orders for	•••••	
	a glass of thicker	ned water and a glass of			thickened liquids and/or		
	1 -	ade placed in front of her.			supplement orders. Supple		
		k on drink of lemonade.			orders will be transcribed or		
		formed the thickener had			Medication Administration to		
					determine compliance rega provision of supplements.		
		tom of the glass of			nurse or QMA on duty durin		
		ater. The liquid at the top			each meal service will person	•	
	_	not thickened. CNA # 2			supervise the the provision		
	then stirred the l	iquids for approximately			thickened liquids . What		
	5 seconds. CNA	#2 then walked away,			measures will be put in pla	асе	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 09/28/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3025 W. SYCAMORE STREET STERLING HOUSE OF KOKOMO KOKOMO, IN46901 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE or what systemic changes will leaving the resident unattended at the the facility make to ensure the table. The resident then took another alleged deficient practice does drink of lemonade. LPN # 1 was then not recur? · Associates who informed the thickener had settled to the provide meal service were bottom of the glasses of liquids. LPN #1 re-educated by the Health and Wellness Director/Designee then stirred the liquids for 10 seconds. regarding the supplement and The lemonade then thickened, but the thickened liquid guidelines. · water did not. LPN #1 then removed the Dining room supervisor is to water and brought back fresh water and double-check thickened liquids for appropriate consistency prior placed thickener into the water and to serving to residents. Health stirred. The water then stay thickened. and Wellness Director/Designee LPN #1, during interview, indicated she will audit MAR daily to ensure did not know why the thickener was supplements have been provided and documented as ordered. settling to the bottom of the glasses. How will the corrective actions be monitored to ensure the Also observed during the lunch meal, deficient practice will not recur. Resident #25 failed to receive her Ensure i.e., what quality assurance supplement. During an interview with programs will be put in place? · The Health and Wellness QMA # 4 at 4 p.m., on 9/27/11, the QMA Director/Designee will monitor indicated the Ensure should have come compliance daily and will report from the kitchen with the meals. findings to the Executive Director weekly. In the event non-compliance is observed, the A undated policy titled "TIPS FOR executive director will determine THICKENING LIQUIDS" was provided next steps for corrective action by the Director of Nursing on 9/28/11 at and follow-up. By what date will 9:20 a.m.. the policy indicated "...stir these systemic changes be immediately for 10 seconds...Allow 3-5 implemented? · 10-15-11 minutes for liquid to reach desired consistency prior to serving....when using small amounts of thickener for syrup/nectar consistencies there may be steeling. [SIC] Re-stir after 3 minutes for consistent product...."

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 09/28/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3025 W. SYCAMORE STREET STERLING HOUSE OF KOKOMO KOKOMO, IN46901 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE (k) The facility must require staff to wash their R0414 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observations, record review, and R0414 R 414 Infection 10/15/2011 **Control-Deficiency What** interviews, the facility failed to ensure corrective action(s) will be handwashing was completed in a manner accomplished for those to prevent the spread of infections and/or residents found to have been disease for 1 of 1 meal service observed affected by the alleged deficient practice? · LPN #1, during 1 of 2 days of the survey. This had C.N.A. #2 and C.N.A. #3 were the potential to affect 33 of 33 residents re-educated by the Health and residing in the facility. Wellness Director/Designee on proper hand washing technique with return demonstration. · No (9/27/11)residents suffered any apparent adverse effects as a result of the Findings include: alleged deficient practice. How will the facility identify other residents with the potential to 1. On 9/27/11 from 12:15 p.m. to 12:50 be affected by the same alleged p.m., the following was observed as lunch deficient practice and what was being served: corrective action will be taken? Other residents as well as LPN #1 was observed to wipe a food spill associates have the potential to be affected by the alleged off of the floor with paper towels. She deficient practice. · The Health then was observed to handwash for 12 and Wellness Director/Designee seconds (secs). Next, she was observed to has completed a hand washing continue to help with the set up of the inservice for associates who assist with meal service. Resident #18's meal. measures will be put in place or what systemic changes will CNA #2 was observed to handwash, turn the facility make to ensure the the water off with her wet hands, and then alleged deficient practice does dried her hands as she continued to check not recur? · The Health and Wellness has posted reminders with the resident in the dining room. regarding proper hand washing

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
			B. WING			09/28/2	011
NAME OF	DDOMDED OD GUDDI IEI		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF	PROVIDER OR SUPPLIER			3025 W	. SYCAMORE STREET		
	NG HOUSE OF KO			L	1O, IN46901		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	1	served to handwash for 10			practices at the common are hand washing sinks for	a	
	seconds, served	applesauce to an			associated to review. · The	20	
	unidentified resi	dent, handwashed for 15			second hand washing rule as		
	seconds, and cor	ntinued to serve the			as safe food handling practic		
	prepared food pl	ates to the residents.			will be part of the orientation		
					training requirement for new		
	CNA #2 was obs	served to continue to pick			associates who handle food.		
		ad/cottage cheese dishes,			How will the corrective		
	1 *	t #21's left arm while			actions be monitored to ens the deficient practice will no		
		nd then, continued to pick			recur, i.e., what quality		
	1	_			assurance programs will be	e put	
	1 -	ad/cottage cheese dishes.			in place? The Manager or		
	No handgel/hand	dwashing was observed.			Duty and/ or Designee will		
					monitor hand washing techni		
	LPN #1 was obs	erved to place a soiled			and document the findings for		
	drinking glass or	n the soiled dish's cart,			weeks. • The hand washing		
	retrieve a clean of	drinking glass from the			monitoring will continue each daily for the next two weeks		
	cabinet, and retu	rned to Resident #18's			monthly thereafter. Result		
	side and began to	o mix up a drink for this			the audits are to be provided		
		ndwashing/handgel use			the Executive Director month	nly for	
	was observed.	2 2			review. · Additional actions		
					be determined by the Execut		
	CNA #3 was obe	served to handwash for			Director, based on findings. what date will these system	-	
		s, fixed Resident #31's			changes be implemented?		
	1				10-15-11		
	1	d it to her. Next, she					
		#17's prepared lunch					
	1 -	r handwashing/handgel					
	was observed.						
	After picking up	several soiled dishes,					
		served to handwash for 12					
	seconds.						
	Seconds.						
	After CNA #3 w	as observed to pass					
		I lunch plate, she began to					
	L another brebaret	i iunon piace, sne oegan to					

NAME OF PROVIDER OR SUPPLIER  STERLING HOUSE OF KOKOMO  (X4)ID SIMMARY STATEMENT OF DESICIONESS  RECHARD HOUSE OF KOKOMO  (X4)ID PREFIX (RACH DEPICIENCY MUST BE PERCEDED BY FULL TAG  handwash, readjusted the water during this handwash, and handwash of 15 seconds.  2. On 9/27/11 at 2:40 p.m. during an interview, LPN #1 indicated one should handwash for the length of the ABC's song. She indicated she did not know how long the time would be.  On 9/28/11 at 1:05 p.m. during an interview, CNA #3 indicated one should handwash for 15 secs. She also indicated if the water needed to be readjusted, the water should be readjusted, the water should be readjusted, the water should be readjusted and the handwashing process should handwash for 20 seconds.  3. The "How to: Hand Washing - Associates" policy was provided by the Administrator on 9/28/11 at 10:40 a.m. This current policy indicated the following:  "Purpose: Handwashing is regarded as the single most important means of preventing the spread of infections	<b>l</b> i '		(X2) MULTIPLE CO		(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  STREAT ADDRESS, CITY, STATE, ZIP CODE  3025 W. SYCAMORE STREET  KOKOMO, INAS90  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  handwash, readjusted the water during this handwash, and handwashed for a total of 15 seconds.  2. On 9/27/11 at 2:40 p.m. during an interview, LPN #1 indicated one should handwash for 15 sees. She also indicated if the water needed to be readjusted, the water should be readjusted, and the handwashing process should be restarted.  On 9/28/11 at 1:40 a.m. during an interview, the Administrator indicated during meal service one should handwash for 20 seconds.  3. The "How to: Hand Washing - Associates" policy was provided by the Administrator on 9/28/11 at 10:40 a.m. This current policy indicated the following:  "Purpose: Handwashing is regarded as the single most important means of preventing the	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
STERLING HOUSE OF KOKOMO    CA3 ID						09/28/2011
STERLING HOUSE OF KOKOMO  KOKOMO, IN48901   SUMMARY STATEMENT OF DEPICIPINCIES   PREFEIX   PRE	NAME OF I	PROVIDER OR SUPPLIER		l		
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Suggested Guidelines:		Suggested Guide	lines:			

	OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMP 09/28/2	LETED
NAME OF PROVIDER OR SUPPLIER STERLING HOUSE OF KOKOMO			STREET A 3025 W	ADDRESS, CITY, STATE, ZIP CO /. SYCAMORE STREET MO, IN46901	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	second hand was performed in situlimited to:* Before touch serving food* After handling contaminated with excretions, or second secon	nation including but not ning, preparing, or ng items potentially th any resident's blood, cretions.				